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Report to Ranking Minority Member, Committee on Veterans' Affairs, U.S. Senate

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VA HEALTH CARE

Physician Peer Review Identifies Quality of Care Problems but Actions to Address Them Are Limited

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GAO

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Health, Education, and
Human Services Division

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The Honorable John D. Rockefeller IV
Ranking Minority Member
Committee on Veterans' Affairs
United States Senate

Dear Senator Rockefeller:

Peer review—physicians reviewing the work of other physicians—is a crucial element in ensuring that quality medical care is provided to patients. When used appropriately, peer review can result in both immediate and long-term improvements in patient care. However, when used inappropriately, it can prevent the detection of poorly performing practitioners and cause severe quality of care problems for patients. An essential element of peer review is management support for actions recommended by the peer review process. Without such support, peer review is a meaningless activity because no action is taken on the peer reviewers' recommendations.

In response to your request, we have examined the relationship between problem identification and problem resolution as it pertains to the Department of Veterans Affairs (VA) physician peer review. Specifically you asked (1) how the results of VA peer review are being used in the process of reprivileging and disciplining physicians with performance problems; (2) what are the impediments to effective peer review; and (3) whether VA was taking action to identify, follow up on, and report to state medical boards and the National Practitioner Data Bank on the actions of those physicians who are not performing in accordance with professional standards.

Our review was conducted at VA's Central Office and six VA medical centers during the period January 1994 through March 1995. At each location we (1) reviewed peer review policies, procedures, and documentation; (2) examined quality assurance files; and (3) interviewed physicians involved in the peer review process. We also examined malpractice claims paid on behalf of physicians at these medical centers. The quality assurance data that we reviewed are considered confidential and privileged under the provisions of Title 38, U.S.C. §5705. Thus, we are not incorporating in this report any examples of cases that VA peer reviewers believed an experienced, competent practitioner would have handled differently. However, these examples will be provided to you

under separate cover. Further details on our scope of work and methodology are contained in appendix I.

Our review was conducted in accordance with generally accepted government auditing standards.

Results in Brief

The peer review process at the six medical centers that we visited has enabled the facilities to identify potential quality of care problems. However, actions taken by VA clinical service chiefs to address these problems were often limited to undocumented discussions with the physicians involved. Further, there was generally no record of the extent to which quality of care problems were addressed or what, if any, action was taken to deal with the problems identified. As a result, corrective actions, if taken, cannot be identified and trends cannot be established to point the way for improvement.

Peer review in both VA and non-VA facilities is a highly subjective process that places heavy reliance on professional judgment. While experts recognize that some element of professional judgment will always be present in peer review, the development of practice guidelines and use of peer review by committee can help to reduce it. VA has begun to develop its own practice guidelines, and some VA medical centers are using the committee approach to peer review.

By establishing restrictive procedures for reporting to the National Practitioner Data Bank, VA medical centers are not reporting to the Data Bank many of the malpractice payments made on behalf of physicians, dentists, and other licensed health care practitioners or the adverse actions[1] taken against physicians' and other practitioners' clinical privileges. Failure to make such reports can result in practitioners who have provided patients with less than optimal care being allowed to (1) leave VA employment with no record of having been involved in a malpractice claim or an adverse action or (2) remain in the VA system without any indication on their record that problems may exist with their performance.

[1]An adverse action is one that results in a reduction, revocation, or suspension of a physician, dentist, or other health care practitioner's clinical privileges, licensure, or membership in a professional society. An adverse action is based on a professional review of a practitioner's professional competence or conduct.

Background

VA employs approximately 10,000 physicians in its 158 medical centers. To help ensure that the care these physicians provide meets accepted professional standards, VA uses several systems to monitor and evaluate physician practice. These systems include surgical case review, external peer review, credentialing and privileging, malpractice claim analysis, and occurrence screens.[2] An integral part of VA's process is physician peer review—physicians evaluating the medical care provided by other physicians.

Peer review in VA is used by medical centers to determine if practitioner care is less than optimal and is initiated when an occurrence screen identifies potential quality of care problems. Peer review is also used to establish the basis for the granting of privileges to physicians and to examine malpractice claims made against health care professionals in the medical center. No disciplinary action is taken against a physician's privileges after a peer review following an occurrence screen. This is because quality assurance information, such as occurrence screen peer review data, is confidential and cannot be used in disciplinary proceedings. However, peer review findings can be used by medical center management to initiate a formal investigation of a physician's performance or conduct after which disciplinary action can be taken.

VA guidance, issued in April 1994, presents various methods for conducting peer review but does not mandate a specific peer review technique. Specifically, the guidance discusses the disadvantages of the single reviewer approach and presents three types of multiple reviewer techniques: (1) committee review, (2) multiple independent review, and (3) discussion to consensus. At the six medical centers we visited, two methods of peer review were being utilized: multiple independent review and committee review. (See app. II for a discussion of these approaches.)

Regardless of the approach used, the result of any peer review is an evaluation of the care provided by a practitioner and a preliminary determination as to how, in the reviewer's opinion, other physicians would have handled the case. Cases rated as a level 1 (most experienced, competent practitioners would handle case similarly) usually receive no further action. Cases rated as a level 2 (most experienced, competent practitioners might handle the case differently) or a level 3 (most experienced, competent practitioners would handle the case differently)

[2]An occurrence screen is the professional review of cases involving adverse outcomes to identify opportunities for improvement of care.

receive a supervisory review by the responsible clinical service chief, such as the chief of surgery.

All physicians and dentists employed by VA are subject to privileging procedures. Privileging is the process by which a practitioner is granted permission by the institution to provide medical or other patient care services within defined limits on the basis of an individual's clinical competence as determined by peer references. Privileging is done at the time of employment and every 2 years thereafter. However, a physician's privileges can be examined at any time if a question about his or her performance or competence is raised.

The National Practitioner Data Bank was created under Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986. The act calls for (1) insurance companies and certain self-insured health care entities to report malpractice payments made for the benefit of a physician, dentist, or other licensed health care practitioner to the Data Bank and (2) hospitals and other authorized health care entities, licensing boards, and professional societies to report professional review actions relating to possible incompetence or improper professional conduct adversely affecting the clinical privileges, licensure, or membership in a professional society of a practitioner for longer than 30 days to the Data Bank.

The intent of the act is to improve the quality of medical care by encouraging physicians, dentists, and other health care practitioners to identify and discipline those who engage in unprofessional behavior and to restrict the ability of incompetent physicians, dentists, and other health care practitioners to move from state to state without disclosure or discovery of their previous damaging or incompetent performance. The Data Bank acts as a clearinghouse for information about licensed practitioners' paid malpractice claims and adverse actions on licensure, clinical privileges, and professional society membership. It has two main functions: (1) responding to queries about practitioners from authorized health care entities and hospitals and (2) collecting and storing adverse actions and malpractice payment information.

Although the act does not require VA medical centers to participate in the Data Bank, it directs the Secretary of Health and Human Services (HHS) to enter into a memorandum of understanding with the Administrator of the Veterans Administration (now VA) to apply the reporting requirements of the act to health care facilities under VA's jurisdiction. Accordingly, a

memorandum of understanding was signed in November 1990, followed by interpretive rules effective October 1991.

Peer Review Process Identifies Quality of Care Problems

VA's physician peer review process is identifying cases needing management attention at the six medical centers that we visited. Specifically, in fiscal year 1993, peer reviewers at these locations reviewed a total of 563 cases referred from the occurrence screen process involving potential quality of care problems. In 373 of these cases, peer reviewers decided that most experienced, competent practitioners would have handled the case similarly; in 136 cases, the peer reviewers believed that most experienced, competent practitioners might have handled the case differently; and in 54 cases, the peer reviewers believed that most experienced, competent practitioners would have handled the case differently.

Each of the VA medical centers that we visited uses occurrence screens to identify potential physician performance problems that may warrant a peer review. Under this process, cases are screened against a predetermined list of criteria, usually by nurses. Those cases that involve one or more of the occurrences will be reviewed to identify possible problems in patient care. Occurrences that are reviewed include, but are not limited to, the following:

- readmittance within 10 days of an inpatient stay;
- readmittance within 3 days of an outpatient visit;
- return to special care unit, such as intensive care;
- return to operating room; and
- death.

Any case for which the occurrence screen results show that a potential quality of care problem may exist is referred to the cognizant service chief for medical peer review. Table 1 shows, by medical center, how the peer reviewers rated the 563 cases.

Table 1: Classification of Occurrence Screen Cases by Peer Reviewers

VA medical center	Level 1	Level 2	Level 3	Total
A	49	11	1	61
B	65	64	19	148
C	75	14	3	92
D	51	9	0	60
E	37	21	14	72
F	96	17	17	130
Total	**373**	**136**	**54**	**563**

Action Taken by Service Chiefs on Peer Review Findings

VA guidance governing peer review of potential quality of care problems identified through occurrence screens states that when peer review indicates that practitioner care is less than optimal, the cases are sent to the service chief for a determination regarding corrective action. The actions chosen by the service chief will be communicated in writing to the chief of staff and the occurrence screen program coordinator. If no action is considered necessary, a notation to that effect should be made by the service chief. However, VA guidance does not explicitly state the extent to which (1) discussions with a practitioner should be documented or (2) the reasons for no action being taken should be justified. As a result, the worksheets provided to the occurrence screen coordinator generally contained no elaboration on the action taken. Of the 50 cases we reviewed where peer reviewers believed that most experienced, competent practitioners would have handled the case differently than the physician under review, 32 resulted in a discussion with the physician, 4 resulted in no action, 8 resulted in a policy change, and 6 resulted in counseling.[3]

Table 2 shows how the service chiefs at the medical centers we visited dealt with cases that their peer reviewers believed most experienced, competent practitioners would have handled differently.

[3]For purposes of this report, a discussion consists of a notation in the occurrence screen worksheets indicating that a discussion was held in a staff meeting, with a practitioner, with a resident, with an attending practitioner, or in an educational conference. However, no details of any of these discussions were provided. Counseling includes actions specified in the occurrence screen worksheets as counseled practitioner (without documentation); formal counseling (letter sent to file); and referral of case for administrative investigation or review.

Table 2: Actions Taken on Cases Peer Reviewers Believed That Most Experienced, Competent Practitioners Would Have Handled Differently

VA medical center	Number of level 3 cases[a]	Discussion	No action taken	Policy/ procedure change	Counseling
A	2	1	0	1	0
B	15	10	1	2	2
C	3	2	0	0	1
D	0	0	0	0	0
E	16	12	1	1	2
F	14	7	2	4	1
Total	**50**	**32**	**4**	**8**	**6**

[a]These numbers refer to the occurrence screen peer review cases we reviewed. The numbers in table 1 refer to all the occurrence screen peer review cases completed at each medical center we visited.

Service chiefs clearly favored a discussion of problems over any other type of action. But in 32 of the 50 level 3 cases in which a discussion took place, when we asked for documentation about what was actually discussed with the practitioner about the peer review findings or what, if any, corrective actions were agreed upon, we were told by staff that they could not find information in either the occurrence screen worksheets or minutes of the service meetings. Further, in the 4 cases we reviewed in which no action was taken by a service chief on peer reviewers' findings, there was no indication in the occurrence screen worksheets as to why a decision to take no action was justified.

VA regulations require cases meeting the occurrence screen criteria to be entered into an ongoing occurrence screen database, which is reviewed and analyzed regularly to identify patterns that may be problematic. However, when actions taken by the service chiefs are not being documented for future reference, corrective actions, if taken, cannot be identified and trends cannot be established to point the way for improvement.

In 14 cases, evidence was present that action was taken on the peer reviewer's findings. Specifically, in 8 cases, medical center management revised certain policies and procedures to ensure that the problems identified by peer reviewers would not recur. In 6 cases, physicians were provided counseling on the basis of the peer reviewer's findings and a record of the incident was placed in the physician's privileging file. The incidents triggering formal counseling included inappropriate medical management of a patient with diabetes; failure to diagnose, monitor, and

treat patients; failure to communicate resuscitation plans for a terminally ill patient; failure to monitor patient response to medication and take appropriate action; and failure to assess a patient and order the correct dose of medication.

Impediments to Effective Peer Review

Experts believe that a significant impediment to effective peer review is the inherent subjectivity involved in determining whether a potential quality of care problem exists. The development of practice guidelines that peer reviewers can use to make performance judgments is one method suggested by experts to reduce the subjectivity. For example, practice guidelines could reduce the tendency on the part of some peer reviewers to focus on the effect of a bad patient outcome rather than whether the standard of care was met.

In a 1992 Journal of the American Medical Association article, an official in VA's Office of Quality Management stated that the development of practice guidelines would be a great aid to improve peer review. In a corroborating article, the physician writing about peer review states that peer judgments regarding appropriateness of care are strongly influenced by perceived outcomes.[4] This suggests that the standard of care is often unclear to reviewers. Practice guidelines are being developed with increasing frequency in both VA and the medical community as a whole. However, at least one expert does not believe that it will be possible to design guidelines that will take into account every possible factor that might constitute an exception to the standard.[5]

Other experts note a tendency of some reviewers to give consistently more lenient or harsh ratings than do others. For example, some suggest that only acknowledged experts should be asked to review the care provided by other practitioners. In their opinion,

> "picking skilled physician-reviewers may be the central and critical step. Simply choosing a peer physician may not be the best strategy; rather, identifying an expert in both the condition under study and in quality assessment purposes and techniques may be required."[6]

[4]Caplan, Robert A., and others, "Effect of Outcome on Physician Judgments of Appropriateness of Care," Journal of the American Medical Association, Vol. 265, No. 15 (1991), pp. 1957-1960.

[5]Chassin, Mark R., "Standards of Care in Medicine," Inquiry, Vol. 25 (1988), pp. 437-453.

[6]Brook, Robert H., and Kathleen N. Lohr, "Monitoring Quality of Care in the Medicare Program," Journal of the American Medical Association, Vol. 258, No. 21 (1987), p. 3138.

At the six medical centers we visited, we found that classification of peer review findings is a highly subjective activity because no systemwide clinical criterion exists for peer reviewers to determine whether physicians would or would not have performed in the same manner as the physician under review. As indicated above, such a situation is not unique to VA and will be resolved only when a complete set of practice guidelines is used routinely. Until such criteria are generally available, a case that might be a level 1 in VA medical center A might be a level 3 in VA medical center F. Levels assigned to cases may also vary among the specialty services within the medical center.

Physician Perceptions of the Peer Review Process in VA Are Mixed

The degree to which the concept of peer review is accepted or embraced by physicians depends to a great extent on how the results of peer review are utilized by medical center management. Although we found differences among services within medical centers, four of the six VA medical centers we visited are using peer review primarily to evaluate physician performance and identify physicians who may have contributed to adverse patient outcomes. This approach is resulting in negative perceptions of the peer review process and is impeding its acceptance among physicians. At these facilities, several physicians questioned the usefulness of the peer review process and did not view it as having an important role in identifying opportunities for improving care.

These physicians contend that peer review duplicates other quality assurance monitors. For example, the medical service units at each of the VA medical centers we visited hold morbidity and mortality conferences to discuss all deaths and clinical complications that occurred during the week preceding the meeting. Some of these cases are later selected for peer review. But, according to physicians involved in peer review, the peer reviews do not identify any issues that are not identified and discussed in the morbidity and mortality conferences.

Physicians also told us that peer review committee findings have more credibility than the findings of a single peer reviewer because the subjectivity inherent in determining quality of care is reduced. Other benefits of the committee approach include identifying the underlying problem that led to an adverse outcome and greater physician acceptance of peer review. Physicians told us that by focusing on the identification of system issues, they are better able to identify the underlying cause of an adverse outcome and prevent it from occurring again.

Physicians who are members of peer review committees also told us that the anonymity associated with peer review committees allows them to be open and honest in their evaluations. Officials from one VA medical center that switched from using a single reviewer to a peer review committee stated that the number of cases rated level 2 or 3 rose when they began using a peer review committee. Specifically, during the first 5 months of 1994, the committee assigned more level 3 designations to cases than did individual reviewers in all of 1993. At another medical center that began using peer review committees, the number of cases rated level 2 or 3 by a committee increased by more than 60 percent.

VA Is Underreporting Malpractice Payments to the Data Bank

The Health Care Quality Improvement Act of 1986 requires that all malpractice claims paid on the behalf of a practitioner be reported to the Data Bank. However, under rules setting forth VA's policy for participation in the Data Bank, VA will file a report with the Data Bank regarding any malpractice payment for the benefit of a physician, dentist, or other licensed practitioner only when the director of the facility at which the act or omission occurred affirms the conclusion of a peer review panel[7] that payment was related to substandard care, professional incompetence, or professional misconduct.[8] Thus, before reporting a practitioner to the Data Bank after a malpractice payment is made, VA is in effect requiring the peer review panel to make a determination that either the standard of care was not met or that a practitioner was guilty of professional incompetence or misconduct. Adherence to these procedures results in VA medical centers' not reporting to the Data Bank all malpractice payments made on behalf of their practitioners.

The process followed by VA medical centers to deal with malpractice claims is as follows: Within 30 days of a claim being filed, the appropriate VA district counsel notifies the medical center involved in providing the medical care identified in the allegations that a claim has been filed. Medical center personnel then conduct a peer review to determine if the appropriate standards of care were met. These standards can relate to any part of the system (for example, hospital, outpatient care, equipment, systems in place, and practitioners). The medical center forwards the results of the peer review along with a copy of the Tort Claim Information

[7]In November 1994, VA issued a directive indicating that a director may not overturn the conclusion of a peer review panel.

[8]Private sector malpractice insurance entities are required to report to the Data Bank the names of practitioners on whose behalf a payment has been made in response to a settlement or adjudication of a claim. There is no assessment of whether the standards of care have been met.

System data and a copy of the patient's medical record to both the Armed Forces Institute of Pathology[9] and the appropriate VA district counsel. Upon receipt of the results of the initial peer review, the district counsel can make a request for the medical opinion of an external expert. Finally, the VA district counsel can settle or deny a claim.

If a payment is made on the claim, the responsible medical center director will convene a second peer review panel to determine if an identifiable licensed health care practitioner is involved in the case. During this review, a determination is made as to whether the acts or omission of the practitioners in relation to the patient injury for which the settlement or judgment was made constituted care that did not meet generally accepted standards of professional competence or conduct. The recommendations of this panel should determine whether the practitioner involved in the incident is reported to the Data Bank. However, before approving the report, the director will notify the practitioner to be reported and provide him or her with an opportunity to discuss the situation with appropriate medical center officials, including the director.

At the six medical centers we visited, we reviewed 53 paid claim files in which the claim alleged that an adverse patient outcome was caused by a licensed practitioner(s). We found that it was possible to determine the practitioner(s) associated with the adverse patient outcome in each of the 53 claims. However, only four of these individuals were reported to the Data Bank. The remaining practitioners were not reported for a variety of reasons, including determination by the panel that the standard of care was met (13); inability to identify the practitioner responsible for the patient (3); problem was considered to be a system failure (4); belief that the resident rather than the attending physician was to blame for the incident (3); patient was at fault (2); no evidence of misconduct, negligence, or malpractice (6); panel split on the need to report (1); and practitioner behavior was not clearly outside the standards of practice (1). Further, from October 28, 1991, to September 30, 1994, only 73 practitioners from 1,047 paid claims for all VA medical centers were reported to the Data Bank. (See app. III.)

In his response to this report, VA's Under Secretary for Health stated that there is not necessarily an identifiable practitioner associated with every malpractice claim because (1) malpractice claims involving VA are filed against the United States of America and typically do not name

[9]The Armed Forces Institute of Pathology began trending tort claims for VA in October 1992. The Institute analyzes the data to determine where problem areas may exist. It issued the first of its periodic reports to VA in April 1994.

practitioners, (2) payments made are on behalf of care provided at a VA facility, and (3) the act or omission for which payment was made is not necessarily practitioner-related. The Under Secretary concluded that (1) the VA peer review process is necessary to determine if there is an identifiable licensed health care provider for whom it can be said that payment was made and (2) only if there is an identifiable practitioner can it be said that the payment was on his or her behalf.

We agree that malpractice claims are filed against the United States of America and not against individual practitioners. We found, however, that identifying practitioners involved in a malpractice claim and on whose behalf it can be said payment was made is not difficult. Our review of 558 malpractice claims involving VA that were paid during fiscal years 1992 and 1993 shows that 422, or 76 percent, involved claims in which it was alleged that an adverse patient outcome was caused by a licensed practitioner(s). Of these practitioners, 409 were physicians.

VA Is Not Reporting Adverse Privileging Actions to the Data Bank

Under its memorandum of understanding with HHS, VA has agreed to report to the Data Bank through state licensing boards any action that for longer than 30 days reduces, restricts, suspends, or revokes the clinical privileges of a physician or dentist due to incompetence or improper professional conduct. However, regardless of the length of time an individual's privileges have been affected, VA will not report adverse actions, including suspensions lasting longer than 30 days, to the Data Bank until all internal appeals have been satisfied. Such a policy is not required by the act and can delay reporting for a considerable time. For example, one VA medical center we visited suspended the privileges of two physicians in 1993 and terminated their employment in 1994. One of these physicians was reinstated in March 1995 with a formal reprimand. As of April 4, 1995, the other was still involved in the internal appeals process. Neither has been reported to the Data Bank.

VA's privileging process includes, among other things, evaluation of a physician's relevant experience and current competence. It also includes consideration of any information related to medical malpractice allegations or judgments, loss of medical staff membership, loss or reduction of clinical privileges, or challenges to licensure. In addition, the evaluation must be determined using evidence of an individual's current competence. Initial privileging is done at the time of employment and every 2 years thereafter. However, a physician's privileges can be

examined at any time if the situation requires it; for example, when there is a question of physician competency or professional conduct.

From October 28, 1991, through September 30, 1994, nine medical centers reported 11 adverse actions to the Data Bank. However, our analysis shows that the adverse reporting rate for VA medical centers is lower than the adverse reporting rate of community hospitals. For example, in California, VA has 4,008 beds and reported 2 adverse actions for an average reporting rate of 0.50 reports per 1,000 beds. Conversely, community hospitals in California have 105,270 beds and reported 390 adverse actions for an average reporting rate of 3.7 reports per 1,000 beds. (See app. IV for a complete reporting comparison by state.)

The Under Secretary for Health, in responding to this report, stated that VA reporting rates are not comparable with community hospital rates because VA practitioners are employees of VA, not independent entrepreneurs. The Under Secretary believes that through appropriate supervision, service chiefs at the medical centers are identifying problems and through supervision and progressive discipline, if necessary, issues are handled before formal privileging actions occur. Conversely, in a community hospital, practitioners are not typically employees of the organization, and the formal privileging review process is the only legitimate process for review. The Under Secretary noted, however, that VA policy requires that licensed health care practitioners who leave VA employment while under investigation be reported to the Data Bank immediately.

Service chiefs at the medical centers we visited told us that they use formal and informal processes to deal with physicians who have performance problems. Formal procedures require due process hearings that (1) take time to administer, (2) require much documentation, and (3) involve extensive understanding of the regulations and guidelines governing such actions. For example, in fiscal years 1993 and 1994, action was taken to officially remove three physicians at the medical centers we visited. The time involved from the initiation of disciplinary action to ultimate removal ranged from 5-1/2 months to a little over 1 year. Reasons for the varying time frames include complexity of the issues involved (such as professional misconduct versus quality of care), multiple independent peer reviews necessary in two cases and not in the other, and the extent to which the physicians fought the disciplinary actions. In each case, the physician's privileges were restricted for more than 30 days; however, only one of the three cases was reported to the Data Bank. VA policy requires that the appeals process be completed before any case is

reported to the Data Bank, and these physicians had appealed the suspension and revocation of their privileges and the termination of their employment.

Service chiefs at the medical centers we visited also used an informal process to remove physicians who had performance problems. However, the effect is that physicians who may have performance problems are not reported to the Data Bank. Further, one service chief told us that he tends to hire part-time physicians to avoid having to adhere to the formal procedures for dealing with problem physicians. The following is an example of a situation that resulted in the removal of a problem physician through informal means.

A service chief reduced a physician's privileges and personally supervised the physician for 6 months to determine the physician's competence level. The service chief concluded that the physicians' medical skills did not improve during the time of observation and recommended to the physician that he resign. The physician took this advice and resigned from the medical center. But no documentation of restricted privileges or other problems appeared in the physician's credentialing and privileging file.

Conclusions

Although physician peer review is performed at the VA medical centers that we visited and cases of questionable quality of care are identified, actions taken by service chiefs as the result of peer review findings are seldom made a matter of record in peer review files. Such information could allow management to track the performance of practitioners over time and help ensure that any pattern of less than optimal care is quickly identified. Documentation also establishes the degree to which management addressed the issues raised by peer reviewers. From an organizational perspective, this establishes accountability on the part of service chiefs, increases practitioner awareness of the importance that the medical center places on the delivery of quality care, and is a good risk-management tool because it requires managers to go on record as to how a potential problem was addressed.

By establishing restrictive Data Bank reporting procedures, VA has shielded its physicians from the professional accountability that is required of private sector practitioners. In so doing, VA could be facilitating the delivery of substandard care outside the VA health care system by allowing practitioners with poor performance records to leave its employment with no record of having been involved in a malpractice claim

or an adverse action. Conversely, failure to report also allows some physicians who provide patients with less than optimal care to remain in the VA system without any indication on their record that problems may exist with their performance.

Recommendations

We recommend that the Secretary of Veterans Affairs direct the Under Secretary for Health to

- require service chiefs to fully document all discussions held with practitioners involved in cases that peer reviewers conclude that most experienced, competent practitioners might or would have handled differently, and
- revise the criteria now being used by medical centers to report VA practitioners to the National Practitioner Data Bank so that they are more consistent with the reporting practices now used in the private sector.

Agency Comments

VA's Under Secretary for Health concurred with our recommendation that service chiefs fully document all discussions held with practitioners and stated that VA will reinforce, on a systemwide basis, the requirement that service chiefs must fully document appropriate actions taken in response to peer review conclusions. The Under Secretary also concurred in principle with our recommendation relating to reporting to the National Practitioner Data Bank. While he does not believe that a change in policy is needed for the reporting of malpractice payments, he does agree that more timely reporting of initial summary suspensions of physician privileges lasting longer than 30 days is an option. In this regard, he said that a group of knowledgeable program staff will explore all policy options and report their recommendations to him by the end of September 1995.

Under VA's current procedures, the postpayment peer review is made to determine if there is an identifiable licensed health care practitioner responsible for a breach in care. The Under Secretary stated that effective May 19, 1995, these reviews will be completed outside of the medical center for which payment was made (for example, in another medical center). This is an interim measure, and VA is in the process of pursuing peer review options that are external to the VA system, such as utilization of the clinical reviewers participating in VA's External Peer Review Program.

We disagree with the Under Secretary's contention that no policy change is needed with respect to the reporting of malpractice payments. VA's policy of reporting only those malpractice payments involving practitioners who have been determined to have breached the standard of care remains more restrictive than required under Public Law 99-660. The law requires only that all malpractice payments made on behalf of a physician or licensed health care practitioner be reported to the Data Bank. In addition, the law states that payment of a claim should not be construed as creating a presumption that medical malpractice has occurred. Thus, any post-payment peer review need only determine that the payment was for the benefit of a practitioner, not that it results from a breach in care.

We also believe that reporting initial summary suspensions rather than only final actions should be viewed as more than an option. VA's memorandum of understanding with HHS clearly states that it will report to the Data Bank any action that for longer than 30 days reduces, restricts, suspends, or revokes the clinical privileges of a physician or dentist due to incompetence or improper professional conduct.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its issue date. At that time, copies will be sent to appropriate congressional committees; the Secretary of Veterans Affairs; the Director, Office of Management and Budget; and other interested parties. We will also make copies available to others upon request.

If you have questions on this report, please contact James Carlan, Assistant Director, Federal Health Care Delivery Issues, on (202) 512-7120. Other staff contributing to this report were team coordinators Patrick Gallagher and Patricia Jones and team members Deena M. El-Attar, Barbara Mulliken, and George Bogart.

Sincerely yours,

David P. Baine

David P. Baine
Director, Federal Health Care
Delivery Issues

Contents

Abbreviations

HHS	Department of Health and Human Services
TCIS	Tort Claim Information System
VA	Department of Veterans Affairs

Scope and Methodology

To accomplish our review, we interviewed VA's medical inspector and officials in VA's Professional Affairs Office, Quality Management Planning and Evaluation Office, Office of Personnel and Labor Relations, and Office of General Counsel. The objective of these interviews was to obtain information on (1) the role of peer review in evaluating physicians and reporting to the National Practitioner Data Bank and state licensing boards and (2) how VA's Tort Claim Information System (TCIS) was developed and is being utilized. We also visited six VA medical centers[10] selected on the basis of the number of paid malpractice claims made on behalf of these facilities. At each location, we (1) interviewed quality assurance personnel, physicians who served as peer reviewers, and service chiefs to obtain their perspectives on the peer review process and (2) reviewed policies and procedures for peer review quality assurance programs, minutes of any meetings that dealt with potential quality of care issues, and documentation pertaining to 191 peer reviews made as a result of an occurrence screen. We also reviewed peer review documentation for 80 tort claims paid and pending for practitioners in 1992 and 1993 at the six medical centers we visited. In addition, we obtained the Armed Forces Institute of Pathology[11] analysis of VA tort claim information for fiscal year 1993 for all VA medical centers and reviewed HHS information on VA's participation in reporting to the Data Bank.

[10]We visited four university affiliated medical centers: Cleveland, Ohio; Houston, Texas; Hines, Illinois; and St. Louis, Missouri. And we visited two nonuniversity affiliated medical centers: Martinsburg, West Virginia, and Fayetteville, North Carolina.

[11]The Armed Forces Institute of Pathology is a triservice organization "sponsored" by the Army Surgeon General's Office. The three Department of Defense services—Army, Navy, Air Force—are required to report all malpractice claims to the Institute. VA has an agreement with this organization wherein the Institute will analyze all VA medical malpractice cases referred to it and report its findings back to VA.

Types of Peer Review Conducted in the Medical Centers We Visited

Under the multiple independent reviewer approach, which is being used at the Cleveland, Hines, and Martinsburg medical centers, physicians selected by the service chief individually review the work of a colleague within the same service; for example, surgeons review the work of other surgeons. During this review, the medical records associated with a case are examined and any physicians or others involved in the case may be interviewed. Each peer reviewer independently evaluates the quality of care involved in the case and makes a preliminary determination as to how, in his or her opinion, other physicians would have handled the case. In those cases where the service chief and a peer reviewer disagree, the service chief's opinion will prevail. The service chief also determines the extent to which follow-up action will be taken on the case.

The Fayetteville, Houston, and St. Louis medical centers use a committee approach to peer review. While each committee is multidisciplinary and comprised of elected or appointed representatives from the major medical services such as surgery and medicine, each committee conducts peer reviews somewhat differently. In Fayetteville, the peer review committee, which consists of all the service chiefs, performs the peer review as a group and determines what action to take. The Houston peer review committee selects individual members of the peer review committee to review cases and present their findings to the entire committee for discussion and level determination. While the committee makes the final peer review level determination, the service chiefs determine what action to take. In St. Louis, all service level peer reviews are submitted to a Quality Assurance/Quality Improvement Committee, which then performs another peer review to validate the original review. The committee has the final decision-making authority regarding the level assigned and will often recommend what action should be taken and then follow up to ensure that the recommended action occurs.

Adverse Action and Malpractice Payment Reports Submitted to the Data Bank, by VA Medical Center (Oct. 28, 1991-Sept. 30, 1994)

VA medical center	Adverse actions reported	Malpractice payments reported
Phoenix, Arizona	•	2
Little Rock, Arkansas	•	3
Livermore, California	•	1
Long Beach, California	1	1
San Diego, California	•	2
California clinics	1	2
Denver, Colorado	•	1
Grand Junction, Colorado	1	1
Bay Pines, Florida	•	1
Gainesville, Florida	•	1
Danville, Illinois	•	1
Hines, Illinois	•	1
North Chicago, Illinois	•	4
Lexington, Kentucky	•	2
New Orleans, Louisiana	•	1
Togus, Maine	•	1
Bedford, Massachusetts	•	1
Boston, Massachusetts	•	1
Battle Creek, Michigan	•	2
Minneapolis, Minnesota	•	3
Biloxi, Mississippi	•	1
Poplar Bluff, Missouri	•	1
St. Louis, Missouri	•	1
Fort Harrison, Montana	•	2
Manchester, New Hampshire	•	1
East Orange, New Jersey	1	•
Lyons, New Jersey	1	1
Albuquerque, New Mexico	•	2
Bronx, New York	1	•
Fayetteville, North Carolina	•	1
Chillicothe, Ohio	•	1
Dayton, Ohio	•	1
Muskogee, Oklahoma	•	1
Portland, Oregon	•	1
Roseburg, Oregon	•	2
Altoona, Pennsylvania	2	2

(continued)

VA medical center	Adverse actions reported	Malpractice payments reported
Erie, Pennsylvania	•	1
Pittsburgh, Pennsylvania	•	2
Wilkes-Barre, Pennsylvania	•	1
Providence, Rhode Island	1	•
Fort Meade, South Dakota	•	1
Mountain Home, Tennessee	•	1
Amarillo, Texas	•	1
Dallas, Texas	•	1
Houston, Texas	1	•
San Antonio, Texas	•	1
Temple, Texas	•	1
Waco, Texas	1	•
Richmond, Virginia	•	1
Salem, Virginia	•	1
Spokane, Washington	•	1
Tacoma, Washington	•	1
Walla Walla, Washington	•	1
Milwaukee, Wisconsin	•	1
Huntington, West Virginia	•	2
Martinsburg, West Virginia	•	1
Undesignated	•	4
Total	**11**	**73**

VA and Community Hospital Adverse Action Reporting Rates Per 1,000 Beds

This appendix presents a comparison of VA's and community hospitals' reported adverse actions per 1,000 hospital beds. This analysis shows that VA hospitals are not reporting at the same rate as other hospitals in the same state. The analysis used information from an HHS Inspector General's report that concluded that most hospitals are underreporting to the Data Bank. VA's adverse action reports are from its first 3 years' participation in the Data Bank, October 28, 1991, through September 30, 1994. The community hospitals' adverse action reports are from the first 3-1/2 years of the Data Bank's operation, September 1, 1990, through December 31, 1993. Only nine VA medical centers in seven states reported adverse actions. Hospitals in all states reported adverse actions.

Table IV.1: VA and Community Hospital Adverse Action Reporting Rates per 1,000 Beds

	VA medical center			Community hospitals		
State	Number of beds	Reports to Data Bank	Reports per 1,000 beds	Number of beds	Reports to Data Bank	Reports per 1,000 beds
Alabama	1,471	0	0.00	23,574	33	1.4
Alaska	0	0	0.00	1,909	6	3.1
Arizona	770	0	0.00	13,629	94	6.9
Arkansas	927	0	0.00	13,328	24	1.8
California	4,008	2	0.50	105,270	390	3.7
Colorado	534	1	1.87	13,691	90	6.6
Connecticut	569	0	0.00	14,238	25	1.8
Delaware	150	0	0.00	2,808	11	3.9
District of Columbia	580	0	0.00	7,527	61	8.1
Florida	2,388	0	0.00	63,415	174	2.7
Georgia	1,450	0	0.00	36,334	91	2.5
Hawaii	0	0	0.00	4,274	6	1.4
Idaho	118	0	0.00	4,045	6	1.5
Illinois	2,789	0	0.00	57,343	84	1.5
Indiana	841	0	0.00	26,143	90	3.4
Iowa	603	0	0.00	17,009	30	1.8
Kansas	871	0	0.00	15,477	52	3.4
Kentucky	916	0	0.00	19,052	43	2.3
Louisiana	855	0	0.00	23,980	35	1.5
Maine	272	0	0.00	6,083	23	3.8
Maryland	987	0	0.00	19,982	70	3.5
Massachusetts	1,942	0	0.00	31,973	55	1.7
Michigan	1,486	0	0.00	39,913	116	2.9
Minnesota	801	0	0.00	24,019	35	1.5

(continued)

State	VA medical center			Community hospitals		
	Number of beds	Reports to Data Bank	Reports per 1,000 beds	Number of beds	Reports to Data Bank	Reports per 1,000 beds
Mississippi	809	0	0.00	17,577	19	1.1
Missouri	1,159	0	0.00	29,455	56	1.9
Montana	153	0	0.00	4,742	10	2.1
Nebraska	399	0	0.00	10,292	30	2.9
Nevada	124	0	0.00	4,144	35	8.5
New Hampshire	108	0	0.00	4,831	17	3.5
New Jersey	1,297	2	1.54	37,796	117	3.1
New Mexico	449	0	0.00	6,867	17	2.5
New York	4,784	1	0.21	102,036	210	2.1
North Carolina	1,375	0	0.00	30,151	52	1.7
North Dakota	119	0	0.00	5,213	11	2.1
Ohio	1,626	0	0.00	51,701	149	2.9
Oklahoma	424	0	0.00	15,100	50	3.3
Oregon	639	0	0.00	10,153	38	3.7
Pennsylvania	3,149	2	0.64	66,298	116	1.8
Rhode Island	156	1	6.41	4,301	9	2.1
South Carolina	579	0	0.00	15,166	29	1.9
South Dakota	506	0	0.00	5,450	4	0.7
Tennessee	1,840	0	0.00	29,420	37	1.3
Texas	3,601	2	0.56	79,982	190	2.4
Utah	305	0	0.00	5,641	20	3.6
Vermont	120	0	0.00	2,290	6	2.6
Virginia	1,298	0	0.00	29,349	124	4.2
Washington	813	0	0.00	15,735	88	5.6
West Virginia	772	0	0.00	10,590	18	1.7
Wisconsin	1,103	0	0.00	23,971	50	2.1
Wyoming	283	0	0.00	3,026	8	2.6

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